

PDP sponsor (or by a parent organization to that PDP sponsor) that recently purchased (or otherwise acquired or merged with) another Part D sponsor if it finds that the benefit package or plan costs represented by that bid are substantially different from any benefit package or plan costs represented by another bid submitted by the same Part D sponsor (or parent organization to that Part D sponsor).

(c) *Limited risk plans.* (1) Application of limited risk plans. There is no limit on the number of full risk plans that CMS approves under paragraph (b) of this section. CMS approves a limited risk plan in accordance with paragraphs (c)(2) and (c)(3) of this section only if the access requirements under § 423.859 are not otherwise met for a PDP region.

(2) *Maximizing assumption of risk.* CMS gives priority in approval for those limited risk plans bearing the highest level of risk, but may take into account the level of the bids submitted by the plans and is not required to accept the limited risk plan with the highest assumption of risk. In no case does CMS approve a limited risk plan under which the modification of risk level provides for no (or a minimal) level of financial risk.

(3) *Limited exercise of authority.* CMS approves only the minimum number of limited risk plans needed to meet the access requirements.

(d) *Special rules for private fee-for-service (PFFS) plans that offer prescription drug coverage.* PFFS plans (as defined at § 422.4(a)(3)) choosing to offer prescription drug coverage are subject to all MA-PD bid submission and approval requirements applicable to MA-PD plans with the following exceptions:

(1) *Exemption from negotiations.* These plans are exempt from the review and negotiation process in paragraph (a) of this section, and are not held to the revenue requirements standard in paragraph (b)(1) of this section.

(2) *Requirements regarding negotiated prices.* These plans are not required to provide access to negotiated prices. However, if they do, they must meet the applicable requirements of § 423.104(h).

(3) *Modification of pharmacy access standard and disclosure requirement.* If

the plan provides coverage for drugs purchased from all pharmacies, without charging additional cost sharing and without regard to whether they are network pharmacies, §§ 423.120(a) and 423.132 requiring certain network access standards and the disclosure of the availability of lower cost bioequivalent generic drugs does not apply to the plan.

(e) *Special rule for plans with standardized bids sufficiently below the national average monthly bid to result in a negative premium.* In the event of a negative premium, as described in § 423.286(d)(1), CMS negotiates the incorporation of the negative premium amount into the bid as either a reduction in the supplemental premium if the Part D plan already submitted a bid with an enhanced alternative benefit, or CMS requires the addition of new enhanced alternative benefit of no less value than the amount of the negative premium.

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§ 423.279 National average monthly bid amount.

(a) *Bids included.* For each year (beginning with 2006) CMS computes a national average monthly bid amount from approved bids submitted under § 423.265 in order to calculate the base beneficiary premium, as provided in § 423.286(c). The national average monthly bid amount is equal to a weighted average of the standardized bid amounts for each prescription drug plan (not including fallbacks) and for each MA-PD plan described in section 1851(a)(2)(A)(i) of the Act. The calculation does not include bids submitted by MSA plans, MA private fee-for-service plans, specialized MA plans for special needs individuals, PACE programs under section 1894, and contracts under reasonable cost reimbursement contracts under section 1876(h) of the Act.

(b) *Calculation of weighted average.* (1) The national average monthly bid amount is a weighted average, with the weight for each plan equal to a percentage with the numerator equal to the number of Part D eligible individuals enrolled in the plan in the reference month (as defined in § 422.258(c)(1) of this chapter) and the denominator equal to the total number

of Part D eligible individuals enrolled in a reference month in all Part D plans except MSA plans, fallbacks, MA private fee-for-service plans, specialized MA plans for special needs individuals, PACE programs under section 1894, and contracts under reasonable cost reimbursement contracts under section 1876(h) of the Act.

(2) For purposes of calculating the monthly national average monthly bid amount for 2006, CMS assigns equal weighting to PDP sponsors (other than fallback entities) and assigns MA-PD plans included in the national average bid a weight based on prior enrollment (new MA-PD plans are assigned zero weight).

(c) *Geographic adjustment.* (1) Upon the development of an appropriate methodology, the national average monthly bid amount for Part D plans will be adjusted to take into account differences in prices for Part D drugs among PDP regions.

(2) CMS does not apply any geographic adjustments if CMS determines that price variations among PDP regions are negligible.

(3) CMS applies any geographic adjustment in a budget neutral manner so as to not result in a change in the aggregate payments that may have been made if CMS had not applied an adjustment.

(4) CMS does not apply any geographic adjustment until an appropriate methodology is developed.

§ 423.286 Rules regarding premiums.

(a) *General rule.* Except as provided in paragraphs (d)(3) and (e) of this section, and with regard to employer group waivers, the monthly beneficiary premium for a Part D plan in a PDP region is the same for all Part D eligible individuals enrolled in the plan. The monthly beneficiary premium for a Part D plan is the base beneficiary premium, as determined in paragraph (c) of this section, adjusted as described in paragraph (d) of this section for the difference between the bid and the national average monthly bid amount, any supplemental benefits and for any late enrollment penalties.

(b) *Beneficiary premium percentage.* The beneficiary premium percentage for any year is a fraction, the—

(1) Numerator of which is 25.5 percent; and

(2) Denominator of which is as follows:

(i) 100 percent minus the percentage established in paragraph (b)(2)(ii) of this section.

(ii) The percentage established in this paragraph equals:

(A) The total reinsurance payments that CMS estimates will be paid under § 423.329(c) for the coverage year; divided by—

(B) The amount estimated under paragraph (b)(2)(ii)(A) of this section for the year plus total payments that CMS estimates will be paid to Part D plans that are attributable to the standardized bid amount during the year, taking into account amounts paid by both CMS and enrollees.

(c) *Base beneficiary premium.* The base beneficiary premium for a Part D plan for a month is equal to the product of the—

(1) Beneficiary premium percentage as specified in paragraph (b) of this section; and

(2) National average monthly bid amount (computed under § 423.279) for the month.

(d) *Adjustments to base beneficiary premium.* The base beneficiary premium may be adjusted to reflect any of the following scenarios, if applicable.

(1) *Adjustment to reflect difference between bid and national average bid.* If the amount of the standardized bid amount exceeds the adjusted national average monthly bid amount, the monthly base beneficiary premium is increased by the amount of the excess. If the amount of the adjusted national average monthly bid amount exceeds the standardized bid amount, the monthly base beneficiary premium is decreased by the amount of the excess. If the amount of the adjusted national average monthly bid amount exceeds the standardized bid amount by an amount greater than the base beneficiary premium and results in a negative premium, then the beneficiary premium is zero, and the excess amount is applied to supplemental Part D benefits as described in § 423.272(e).

(2) *Increase for supplemental prescription drug benefits.* The portion of the